Filing at a Glance

Company:	QCA Health Plan, Inc.
Product Name:	QualChoice Group POS
State:	Arkansas
TOI:	H16G Group Health - Major Medical
Sub-TOI:	H16G.001B Any Size Group - POS
Filing Type:	Form
Date Submitted:	10/16/2012
SERFF Tr Num:	QUAC-128726925
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	
Implementation Date Requested:	On Approval
Author(s):	Jim Couch, Liz Hubbard
Reviewer(s):	Rosalind Minor (primary)
Disposition Date:	10/17/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: *Arkansas* **Filing Company:** *QCA Health Plan, Inc.*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.001B Any Size Group - POS*
Product Name: *QualChoice Group POS*
Project Name/Number: */*

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 10/17/2012
State Status Changed: 10/17/2012
Created By: Jim Couch
Corresponding Filing Tracking Number:

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small and Large
Overall Rate Impact:

Deemer Date:
Submitted By: Jim Couch

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Filing Description:
Modified Benefits Summaries (both Medical and Prescription Drug) to reflect contraceptive coverage under ACA.

Company and Contact

Filing Contact Information

Jim Couch, VP of Compliance
12615 Chenal Parkway, Suite 300
Little Rock, AR 72211

jim.couch@qualchoice.com
501-228-7111 [Phone] 5118 [Ext]
501-707-6729 [FAX]

Filing Company Information

QCA Health Plan, Inc.
12615 Chenal Parkway, Suite 300
Little Rock, AR 72211
(501) 228-7111 ext. [Phone]

CoCode: 95448
Group Code:
Group Name:
FEIN Number: 71-0794605

State of Domicile: Arkansas
Company Type: Health Maintenance Organization
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: $400.00
Retaliatory? No
Fee Explanation: 8 forms * $50.00/form = $400.00
Per Company: No

Company	Amount	Date Processed	Transaction #
QCA Health Plan, Inc.	$400.00	10/16/2012	63949677

State: *Arkansas* **Filing Company:** *QCA Health Plan, Inc.*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.001B Any Size Group - POS*
Product Name: *QualChoice Group POS*
Project Name/Number: */*

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/17/2012	10/17/2012

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Benefit Summary Modifications for QCA Health Plan's POS Products	Note To Reviewer	Jim Couch	10/16/2012	10/16/2012

State:	*Arkansas*	**Filing Company:**	*QCA Health Plan, Inc.*
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.001B Any Size Group - POS*		
Product Name:	*QualChoice Group POS*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 10/17/2012
Implementation Date:
Status: Approved-Closed
HHS Status: HHS Approved
State Review: Reviewed-No Actuary
Comment:

Rate data does NOT apply to filing.

State: Arkansas **Filing Company:** QCA Health Plan, Inc.
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001B Any Size Group - POS
Product Name: QualChoice Group POS
Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	QualChoice FlexChoice Benefit Summary Grandfathered Benefit Plan	Approved-Closed	Yes
Form	QualChoice FlexChoice Benefit Summary Non-Grandfathered Benefit Plan	Approved-Closed	Yes
Form	QualChoice PreferredChoice Benefit Summary Non-Grandfathered Benefit Plan	Approved-Closed	Yes
Form	QualChoice Preferred Choice Benefit Summary Grandfathered Plan	Approved-Closed	Yes
Form	QualChoice RightChoice Benefit Summary Grandfathered Benefit Plan	Approved-Closed	Yes
Form	QualChoice RightChoice Benefit Summary Non-Grandfathered Benefit Plan	Approved-Closed	Yes
Form	QualChoice Outpatient Prescription Drug Plan [Enhanced or Core or Basic] Benefit Summary	Approved-Closed	Yes
Form	QualChoice Outpatient Prescription Drug Plan [Enhanced or Core or Basic] HDHP Benefit Summary	Approved-Closed	Yes

State: *Arkansas* **Filing Company:** *QCA Health Plan, Inc.*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.001B Any Size Group - POS*
Product Name: *QualChoice Group POS*
Project Name/Number: */*

Note To Reviewer

Created By:

Jim Couch on 10/16/2012 05:14 PM

Last Edited By:

Rosalind Minor

Submitted On:

10/17/2012 12:43 PM

Subject:

Benefit Summary Modifications for QCA Health Plan's POS Products

Comments:

The changes reflected in these modified medical and Rx benefit summaries are necessary to reflect the change in contraception coverage for women at no cost share under ACA.

State: Arkansas **Filing Company:** QCA Health Plan, Inc.
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001B Any Size Group - POS
Product Name: QualChoice Group POS
Project Name/Number: /

Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 10/17/2012		SCH	QualChoice FlexChoice Benefit Summary Grandfathered Benefit Plan	Initial:		FlexChoice GF 8.2012 Womens Health for Filing.pdf
2	Approved-Closed 10/17/2012		SCH	QualChoice FlexChoice Benefit Summary Non-Grandfathered Benefit Plan	Initial:		FlexChoice NG 8.2012 Womens Health for Filing.pdf
3	Approved-Closed 10/17/2012		SCH	QualChoice PreferredChoice Benefit Summary Non-Grandfathered Benefit Plan	Initial:		Preferred Choice NG 8.2012 Womens Health for Filing.pdf
4	Approved-Closed 10/17/2012		SCH	QualChoice Preferred Choice Benefit Summary Grandfathered Plan	Initial:		PreferredChoice GF 8.2012 Womens Health for Filing.pdf
5	Approved-Closed 10/17/2012		SCH	QualChoice RightChoice Benefit Summary Grandfathered Benefit Plan	Initial:		RightChoice GF 8.2012 Womens Health for Filing.pdf
6	Approved-Closed 10/17/2012		SCH	QualChoice RightChoice Benefit Summary Non-Grandfathered Benefit Plan	Initial:		RightChoice NG 8.2012 Womens Health for Filing.pdf
7	Approved-Closed 10/17/2012		SCH	QualChoice Outpatient Prescription Drug Plan [Enhanced or Core or Basic] Benefit Summary	Initial:		POS Rx 8.2012 Womens Health for Filing.pdf
8	Approved-Closed 10/17/2012		SCH	QualChoice Outpatient Prescription Drug Plan [Enhanced or Core or Basic] HDHP Benefit Summary	Initial:		POS HDHP Rx 8.2012 Womens Health for Filing.pdf

State: *Arkansas* **Filing Company:** *QCA Health Plan, Inc.*
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Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

This benefit summary is part of the Evidence of Coverage (EOC), Form QCA POS (10/1/10) as amended by FIRST AMENDMENT with Autism to QCA POS (10-1-10) EOC (8-1-2011) and subject to all benefit terms and conditions, limitations and exclusions included in the Evidence of Coverage. This benefit summary is intended only to highlight your benefits and should not be relied upon soley to determine coverage. Please refer to the Evidence of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. In the event the language in the Evidence of Coverage is different than this benefit summary, the Evidence of Coverage prevails.

For both In-Network and Out-of-Network Benefits, some services may require pre-authorization by QualChoice. For details and to access the most current listing of services requiring pre-authorization, visit our website at www.qualchoice.com.

All benefit payments are based on the QualChoice Maximum Allowable Charge. Use of an Out-of-Network Provider may result in you being balance billed and higher out-of-pocket costs. Amounts in excess of the QualChoice Maximum Allowable Charge do not count toward annual Deductible or Coinsurance limits. See the "Member Financial Responsibility Comparison" section in the Evidence of Coverage.

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Annual Deductible ▪ Co-payments are not included in the annual Deductible ▪ In-Network and Out-of-Network Deductibles apply separately ▪ Family Deductible is not considered satisfied until at least **[2 to 5]** separate family members have satisfied their individual Deductibles ▪ Deductible amounts applied in the last quarter of a Calendar Year will carry over to the next Calendar Year ▪ The annual Deductible is calculated on a Calendar Year basis	**Individual: [$0-[$0-$2,000],000]** **Family: [$0-[$0-$2,000],000]**	**Individual: [$0-[$0-$2,000],000]** **Family: [$0-[$0-$2,000],000]**
Annual Out-of-Pocket Limit ▪ Applicable Coinsurance will apply until **[2 to 5]** separate family members meet their individual Out-of-Pocket Limits satisfying the family out-of-pocket limit ▪ Benefits will be paid at 100% of the Maximum Allowable Charge once the family annual Coinsurance limit is satisfied ▪ Out-of-Pocket limits apply separately to In-Network and Out-of-Network Benefits ▪ Co-payments do not apply toward your Out-of-Pocket Limit. You will continue to be responsible for Co-payments once the Out-of-Pocket Limit is reached ▪ Out-of-Pocket Limit & benefit limits are calculated on a Calendar Year basis	Individual: **[$0-$500,000]** Family: **[$0-$1,000,000]**	Individual: **[$0-$500,000]** Family: **[$0-$1,000,000]**
Coinsurance	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Preventive Care Services (Performed in the Office):		
QualChoice preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved QualChoice medical polices. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and QualChoice medical policies.		
Immunizations, including flu and pneumonia vaccines **Child Immunizations (age 0-18)** **Adult Immunizations (age 18+)** ▪ Diphtheria and Tetanus toxoid for ages over seven (Td), every 10 years ▪ Hepatitis B (Hep B) - once per lifetime ▪ Influenza, annually ▪ Pneumococcal Conjugate, adult over 55 or immunosuppressed ▪ Zoster, adult 60 and older ▪ HPV (covered age 9-18, females only) *Note: Immunizations for travel, school, work or recreation are not covered. See the "Physician Office Services" section in the Evidence of Coverage (EOC).*	Paid in Full	
Routine vision exam (limit 1 every 24 months)	**[$0-$500] Co-payment**	Not Covered
Well baby care, birth - to age 2	**[$0-$500] Co-payment**	[0%-100%] after Deductible
Well child care, ages 2-18	**[$0-$500] Co-payment**	[0%-100%] after Deductible
Other preventive services ▪ Annual physical ▪ Pap smear ▪ Screening mammogram (including breast exam) age 40 and over ▪ Prostate screenings for men age 40 and over	PCP: [$0-$500] Co-payment or Specialist: [$0-$500] Co-payment	[0%-100%] after Deductible

Preventive Care Services, continued	In-Network (You Pay)	Out-of-Network (You Pay)
Other preventive services, continued ▪ Bone density screening tests, preventive for women age 65+ ▪ Fecal occult blood test annually	**PCP: [$0-$500] Co-payment or Specialist: [$0-$500] Co-payment**	**[0%-100%] after Deductible**
▪ Flexible sigmoidoscopy once every 5 years; OR ▪ Double contrast barium enema once every 5 years; OR ▪ Preventive colonoscopy age 50 and older, once every 10 years	**[0%-100%] after Deductible and [$0-$2,000] Co-payment**	[0%-100%] after Deductible
Family Planning ▪ Tubal ligation and associated services (reversal of sterilization is not a covered ▪ Insertion or implantation of birth control pellets, capsules or IUDs ▪ Fitting and insertion of diaphragms, rings or caps ▪ Injection of long acting contraceptives	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Smoking cessation ▪ Kick the Nic: smoking cessation; 12 week program *Note: Contact QCARE 1-888-795-6810*	No Cost to You	Not Covered
Professional Services		
Primary Care Physician (PCP) Office Visit ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures ▪ Routine Injectible Prescription Medications which include: 1st generation antibiotics, topical and local anesthesia, steroid, hormone and vitamin injections	**[$0-$500] Co-payment**	**[0%-100%] after Deductible**
Specialist Office Visit ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures	**[$0-$500] Co-payment**	**[0%-100%] after Deductible**
Professional services that are subject to Deductible and Coinsurance (in addition to the office Co-payment) ▪ Complex diagnostic services, such as advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests ▪ Other procedures - chemotherapy, radiation therapy and infusion therapy ▪ Complex Injectible Prescription Medications which include: All specialty medications such as enbrel, humira, IV medications and high potency antibiotics (when obtained at a pharmacy, see *"Outpatient Prescription Drug Benefit Summary"* ▪ Complex procedures such as cystoscopy, colposcopy and invasive biopsies ▪ Services and procedures provided by a physician in a facility	**PCP: [$0-$500] Co-payment or Specialist: [$0-$500] Co-payment and [0%-100%] after Deductible**	**[0%-100%] after Deductible**
Inpatient Care - Room and Board		
▪ Inpatient care - room and board ▪ Skilled Nursing Facility and Inpatient Rehabilitation Services (combined 30 day limit per Calendar Year)	**[0%-100%] after Deductible and [$0-$2,000] Co-payment**	**[0%-100%] after Deductible**
Outpatient Care and Ambulatory Care Centers		
▪ Outpatient Care and Ambulatory Care Centers ▪ Observation Services ▪ Diagnostic Services - Advanced imaging, Lab & X-Ray ▪ Hospice services (limited to a lifetime maximum of 180 days) ▪ Home Health Care (40 visits per Calendar Year)	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
▪ Outpatient Surgical Services	**[0%-100%] after Deductible and [$0-$2,000] Co-payment**	**[0%-100%] after Deductible**
Emergency Services		
▪ Emergency Room, Urgent Care or ER Observation Services	**[0%-100%] after [$0-$2,000] Co-payment**	**[0%-100%] after [$0-$2,000] Co-payment**
Transportation Services		
▪ Ambulance - Ground or Air ($1,000 maximum benefit per Calendar Year) *Note: Facility to facility ambulance transfer requires pre-authorization.*	**[0%-100%]**	**[0%-100%]**
Therapy Services		
▪ Physical Therapy ▪ Occupational Therapy ▪ Speech Therapy and Audiology Testing ▪ Chiropractic Care ▪ Cardiac Rehabilitation (36 visits per Calendar Year) *Note: Therapy services are limited to a combined maximum of 30 visits per Calendar Year. This does not include Cardiac Rehabilitation*	**[$0-$500] Co-payment**	**[0%-100%] after Deductible**

Maternity Services	In-Network (You Pay)	Out-of-Network (You Pay)
Physician Services ▪ Routine Prenatal Lab	**[Paid in full] or [0%-100%] after Deductible**	**[0%-100%] after Deductible**
▪ Initial Office Visit	**[$0-$500] Co-payment**	
▪ All other services	**[0%-100%] after Deductible**	
Facility Services	**[0%-100%] after Deductible and [$0-$2,000] Co-payment**	
Infertility Diagnostic Services Only *Note: Treatment of infertility is not covered.*	**[0%-100%] after Deductible**	**Not Covered**
Mental Health and Substance Use Disorder Services		
▪ Inpatient Hospital Services - **[10 day limit per calendar year]**	**[0%-100%] after Deductible and [$0-$2,000] Co-payment**	**[0%-100%] after Deductible or [Not Covered]**
▪ Professional Services (Office/**Outpatient** Visits) **[10 visit limit per calendar year]**	**[$0-$500] Co-payment**	
▪ Professional Services (Inpatient/**Outpatient** Facility)	**[0%-100%] after Deductible**	
Allergy Services		
▪ Office Visit and Allergy Testing	**PCP: [$0-$500] Co-payment or Specialist: [$0-$500] Co-payment**	**[0%-100%] after Deductible**
▪ Allergy Shots	Paid in Full	**[0%-100%] after Deductible**
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME) ▪ $2,000 maximum benefit per Calendar Year	**[0%-100%] after Deductible**	**Not Covered**
Medical Supplies ▪ Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately.	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
▪ Provided in connection with home infusion therapy	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
▪ Provided in connection with Durable Medical Equipment	**[0%-100%] after Deductible**	**Not Covered**
Prosthetic and Orthotic Services and Devices ▪ Prosthetic Services and Prosthetic Devices ▪ Orthotic Services and Orthotic Devices *Note: QualChoice does not cover replacement or associated services more frequently than (1) time every three years unless Medically Necessary. See your Evidence of Coverage for more information.*	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Reconstructive Surgery ▪ Breast reconstruction following mastectomy for cancer ▪ Restoration due to acute trauma, infection or cancer *Note: These benefits are for physician/professional charges. For benefits related to these services for Inpatient or Outpatient charges, see Inpatient or Outpatient sections on page 2.*	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Transplantation Services ▪ Physician/Professional charges	**[0%-100%] after Deductible**	**Not Covered**
▪ Inpatient and Outpatient Charges *Note: Lifetime maximum of two transplants*	**[0%-100%] after Deductible and [$0-$200] Co-payment**	
Diabetes Management Services ▪ Insulin Pumps ($5,500 benefit maximum per Calendar Year)	**[0%-100%] after Deductible**	
▪ Supplies and equipment (Subject to $2,000 DME limit)	**[0%-100%] after Deductible**	**Not Covered**
▪ Diabetic Education (1 training per lifetime)	**[$0-$500] Co-payment**	**[0%-100%] after Deductible**
Dental Care ▪ Accidental injury to sound and natural teeth $2,000 maximum benefit per accident	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Medical Foods for Phenylketonuria ▪ Benefits available after member has paid $2,400 per year	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Genetic Counseling and Testing *Note: Genetic testing is typically not covered, except in rare situations. When covered, these tests are subject to Deductible and Coinsurance. Talk with your physician. If genetic testing is done and there is no pre-authorization, you will be responsible for the charges. See medical policies at www.qualchoice.com for more information.*	No benefits if not pre-authorized **[0%-100%] after Deductible**	No benefits if not pre-authorized **[0%-100%] after Deductible**

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For both In-Network and Out-of-Network Benefits, some services may require pre-authorization by QualChoice. For details and to access the most current listing of services requiring pre-authorization, visit our website at www.qualchoice.com.

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Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Annual Deductible ▪ Co-payments are not included in the annual Deductible ▪ In-Network and Out-of-Network Deductibles apply separately ▪ Family Deductible is not considered satisfied until at least **[2 to 5]** separate family members have satisfied their individual Deductibles ▪ Deductible amounts applied in the last quarter of a Calendar Year will carry over to the next Calendar Year ▪ The annual Deductible is calculated on a Calendar Year basis	**Individual: [$0-[$0-$2,000],000]** **Family: [$0-[$0-$2,000],000]**	**Individual: [$0-[$0-$2,000],000]** **Family: [$0-[$0-$2,000],000]**
Annual Out-of-Pocket Limit ▪ Applicable Coinsurance will apply until **[2 to 5]** separate family members meet their individual Out-of-Pocket Limits satisfying the family out-of-pocket limit ▪ Benefits will be paid at 100% of the Maximum Allowable Charge once the family annual Coinsurance limit is satisfied ▪ Out-of-Pocket limits apply separately to In-Network and Out-of-Network Benefits ▪ Co-payments do not apply toward your Out-of-Pocket Limit. You will continue to be responsible for Co-payments once the Out-of-Pocket Limit is reached ▪ Out-of-Pocket Limit & benefit limits are calculated on a Calendar Year basis	Individual: **[$0-$500,000]** Family: **[$0-$1,000,000]**	Individual: **[$0-$500,000]** Family: **[$0-$1,000,000]**
Coinsurance	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Preventive Care Services (Performed in the Office):		
QualChoice preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved QualChoice medical polices. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and QualChoice medical policies.		
Immunizations, including flu and pneumonia vaccines **Child Immunizations (age 0-18)** **Adult Immunizations (age 18+)** ▪ Diphtheria and Tetanus toxoid for ages over seven (Td), every 10 years ▪ Hepatitis B (Hep B) - once per lifetime ▪ Influenza, annually ▪ Pneumococcal Conjugate, adult over 55 or immunosuppressed ▪ Zoster, adult 60 and older ▪ HPV (covered age 9-18, females only) *Note: Immunizations for travel, school, work or recreation are not covered. See the "Physician Office Services" section in the Evidence of Coverage (EOC).*	Paid in Full	
Routine vision exam (limit 1 every 24 months)	[$0-$500] Co-payment	Not Covered
Well baby care, birth - to age 2	No Cost to You	Not Covered
Well child care, ages 2-18	No Cost to You	Not Covered
Other preventive services ▪ Annual physical ▪ Pap smear ▪ Screening mammogram (including breast exam) age 40 and over ▪ Prostate screenings for men age 40 and over	No Cost to You No Cost to You	Not Covered

Preventive Care Services, continued	**In-Network (You Pay)**	**Out-of-Network (You Pay)**
Other preventive services, continued ▪ Bone density screening tests, preventive for women age 65+ ▪ Fecal occult blood test annually	No Cost to You	Not Covered
▪ Flexible sigmoidoscopy once every 5 years; OR ▪ Double contrast barium enema once every 5 years; OR ▪ Preventive colonoscopy age 50 and older, once every 10 years	No Cost to You	Not Covered
Family Planning ▪ Tubal ligation and associated services (reversal of sterilization is not a covered ▪ Insertion or implantation of birth control pellets, capsules or IUDs ▪ Fitting and insertion of diaphragms, rings or caps ▪ Injection of long acting contraceptives	No Cost to You	Not Covered
Smoking cessation ▪ Kick the Nic: smoking cessation; 12 week program *Note: Contact QCARE 1-888-795-6810*	No Cost to You	Not Covered
Professional Services		
Primary Care Physician (PCP) Office Visit ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures ▪ Routine Injectible Prescription Medications which include: 1st generation antibiotics, topical and local anesthesia, steroid, hormone and vitamin injections	**[$0-$500] Co-payment**	**[0%-100%] after Deductible**
Specialist Office Visit ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures	**[$0-$500] Co-payment**	**[0%-100%] after Deductible**
Professional services that are subject to Deductible and Coinsurance (in addition to the office Co-payment) ▪ Complex diagnostic services, such as advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests ▪ Other procedures - chemotherapy, radiation therapy and infusion therapy ▪ Complex Injectible Prescription Medications which include: All specialty medications such as enbrel, humira, IV medications and high potency antibiotics (when obtained at a pharmacy, see *"Outpatient Prescription Drug Benefit Summary"* ▪ Complex procedures such as cystoscopy, colposcopy and invasive biopsies ▪ Services and procedures provided by a physician in a facility	**PCP: [$0-$500] Co-payment or Specialist: [$0-$500] Co-payment and [0%-100%] after Deductible**	**[0%-100%] after Deductible**
Inpatient Care - Room and Board		
▪ Inpatient care - room and board ▪ Skilled Nursing Facility and Inpatient Rehabilitation Services (combined 30 day limit per Calendar Year)	**[0%-100%] after Deductible and [$0-$2,000] Co-payment**	**[0%-100%] after Deductible**
Outpatient Care and Ambulatory Care Centers		
▪ Outpatient Care and Ambulatory Care Centers ▪ Observation Services ▪ Diagnostic Services - Advanced imaging, Lab & X-Ray ▪ Hospice services (limited to a lifetime maximum of 180 days) ▪ Home Health Care (40 visits per Calendar Year)	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
▪ Outpatient Surgical Services	**[0%-100%] after Deductible and [$0-$2,000] Co-payment**	**[0%-100%] after Deductible**
Emergency Services		
▪ Emergency Room, Urgent Care or ER Observation Services	**[0%-100%] after [$0-$2,000] Co-payment**	**[0%-100%] after [$0-$2,000] Co-payment**
Transportation Services		
▪ Ambulance - Ground or Air ($1,000 maximum benefit per Calendar Year) *Note: Facility to facility ambulance transfer requires pre-authorization.*	**[0%-100%]**	**[0%-100%]**
Therapy Services		
▪ Physical Therapy ▪ Occupational Therapy ▪ Speech Therapy and Audiology Testing ▪ Chiropractic Care ▪ Cardiac Rehabilitation (36 visits per Calendar Year) *Note: Therapy services are limited to a combined maximum of 30 visits per Calendar Year. This does not include Cardiac Rehabilitation*	**[$0-$500] Co-payment**	**[0%-100%] after Deductible**

Maternity Services	In-Network (You Pay)	Out-of-Network (You Pay)
Physician Services ▪ Routine Prenatal Lab	**[Paid in full] or [0%-100%] after Deductible**	**[0%-100%] after Deductible**
▪ Initial Office Visit	**[$0-$500] Co-payment**	
▪ All other services	**[0%-100%] after Deductible**	
Facility Services	**[0%-100%] after Deductible and [$0-$2,000] Co-payment**	
Infertility Diagnostic Services Only *Note: Treatment of infertility is not covered.*	**[0%-100%] after Deductible**	**Not Covered**
Mental Health and Substance Use Disorder Services		
▪ Inpatient Hospital Services - **[10 day limit per calendar year]**	**[0%-100%] after Deductible and [$0-$2,000] Co-payment**	**[0%-100%] after Deductible or [Not Covered]**
▪ Professional Services (Office/**Outpatient** Visits) **[10 visit limit per calendar year]**	**[$0-$500] Co-payment**	
▪ Professional Services (Inpatient/**Outpatient** Facility)	**[0%-100%] after Deductible**	
Allergy Services		
▪ Office Visit and Allergy Testing	**PCP: [$0-$500] Co-payment or Specialist: [$0-$500] Co-payment**	**[0%-100%] after Deductible**
▪ Allergy Shots	Paid in Full	**[0%-100%] after Deductible**
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME) ▪ $2,000 maximum benefit per Calendar Year	**[0%-100%] after Deductible**	**Not Covered**
Medical Supplies ▪ Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately.	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
▪ Provided in connection with home infusion therapy	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
▪ Provided in connection with Durable Medical Equipment	**[0%-100%] after Deductible**	**Not Covered**
Prosthetic and Orthotic Services and Devices ▪ Prosthetic Services and Prosthetic Devices ▪ Orthotic Services and Orthotic Devices *Note: QualChoice does not cover replacement or associated services more frequently than (1) time every three years unless Medically Necessary. See your Evidence of Coverage for more information.*	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Reconstructive Surgery ▪ Breast reconstruction following mastectomy for cancer ▪ Restoration due to acute trauma, infection or cancer *Note: These benefits are for physician/professional charges. For benefits related to these services for Inpatient or Outpatient charges, see Inpatient or Outpatient sections on page 2.*	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Transplantation Services ▪ Physician/Professional charges	**[0%-100%] after Deductible**	**Not Covered**
▪ Inpatient and Outpatient Charges *Note: Lifetime maximum of two transplants*	**[0%-100%] after Deductible and [$0-$200] Co-payment**	
Diabetes Management Services ▪ Insulin Pumps ($5,500 benefit maximum per Calendar Year)	**[0%-100%] after Deductible**	
▪ Supplies and equipment (Subject to $2,000 DME limit)	**[0%-100%] after Deductible**	**Not Covered**
▪ Diabetic Education (1 training per lifetime)	**[$0-$500] Co-payment**	**[0%-100%] after Deductible**
Dental Care ▪ Accidental injury to sound and natural teeth $2,000 maximum benefit per accident	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Medical Foods for Phenylketonuria ▪ Benefits available after member has paid $2,400 per year	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Genetic Counseling and Testing *Note: Genetic testing is typically not covered, except in rare situations. When covered, these tests are subject to Deductible and Coinsurance. Talk with your physician. If genetic testing is done and there is no pre-authorization, you will be responsible for the charges. See medical policies at www.qualchoice.com for more information.*	No benefits if not pre-authorized **[0%-100%] after Deductible**	No benefits if not pre-authorized **[0%-100%] after Deductible**

This benefit summary is part of the Evidence of Coverage (EOC), Form QCA POS (10/1/10) as amended by FIRST AMENDMENT with Autism to QCA POS (10-1-10) EOC (8-1-2011) and subject to all benefit terms and conditions, limitations and exclusions included in the Evidence of Coverage. This benefit summary is intended only to highlight your benefits and should not be relied upon soley to determine coverage. Please refer to the Evidence of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. In the event the language in the Evidence of Coverage is different than this benefit summary, the Evidence of Coverage prevails.

For both In-Network and Out-of-Network Benefits, some services may require pre-authorization by QualChoice. For details and to access the most current listing of services requiring pre-authorization, visit our website at www.qualchoice.com.

All benefit payments are based on the QualChoice Maximum Allowable Charge. Use of an Out-of-Network Provider may result in you being balance billed and higher out-of-pocket costs. Amounts in excess of the QualChoice Maximum Allowable Charge do not count toward annual Deductible or Coinsurance limits. See the "Member Financial Responsibility Comparison" section in the Evidence of Coverage.

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Annual Deductible ▪ Co-payments are not included in the annual Deductible ▪ In-Network and Out-of-Network Deductibles apply separately ▪ Family Deductible is not considered satisfied until at least **[2 to 5]** separate family members have satisfied their individual Deductibles ▪ Deductible amounts applied in the last quarter of a Calendar Year will carry over to the next Calendar Year ▪ The annual Deductible is calculated on a Calendar Year basis	**Individual: [$0-[$0-$2,000],000]** **Family: [$0-[$0-$2,000],000]**	**Individual: [$0-[$0-$2,000],000]** **Family: [$0-[$0-$2,000],000]**
Annual Out-of-Pocket Limit ▪ Applicable Coinsurance will apply until **[2 to 5]** separate family members meet their individual Out-of-Pocket Limits satisfying the family out-of-pocket limit ▪ Benefits will be paid at 100% of the Maximum Allowable Charge once the family annual Coinsurance limit is satisfied ▪ Out-of-Pocket limits apply separately to In-Network and Out-of-Network Benefits ▪ Co-payments do not apply toward your Out-of-Pocket Limit. You will continue to be responsible for Co-payments once the Out-of-Pocket Limit is reached ▪ Out-of-Pocket Limit & benefit limits are calculated on a Calendar Year basis	Individual: **[$0-$500,000]** Family: **[$0-$1,000,000]**	Individual: **[$0-$500,000]** Family: **[$0-$1,000,000]**
Coinsurance	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Preventive Care Services (Performed in the Office):		
QualChoice preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved QualChoice medical polices. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and QualChoice medical policies.		
Immunizations, including flu and pneumonia vaccines **Child Immunizations (age 0-18)** **Adult Immunizations (age 18+)** ▪ Diphtheria and Tetanus toxoid for ages over seven (Td), every 10 years ▪ Hepatitis B (Hep B) - once per lifetime ▪ Influenza, annually ▪ Pneumococcal Conjugate, adult over 55 or immunosuppressed ▪ Zoster, adult 60 and older ▪ HPV (covered age 9-18, females only) *Note: Immunizations for travel, school, work or recreation are not covered. See the "Physician Office Services" section in the Evidence of Coverage (EOC).*	Paid in Full	
Routine vision exam (limit 1 every 24 months)	[$0-$500] Co-payment	Not Covered
Well baby care, birth - to age 2	No Cost to You	Not Covered
Well child care, ages 2-18	No Cost to You	Not Covered
Other preventive services ▪ Annual physical ▪ Pap smear ▪ Screening mammogram (including breast exam) age 40 and over ▪ Prostate screenings for men age 40 and over	No Cost to You	Not Covered

Preventive Care Services, continued	In-Network (You Pay)	Out-of-Network (You Pay)
Other preventive services, continued ▪ Bone density screening tests, preventive for women age 65+ ▪ Fecal occult blood test annually	No Cost to You	Not Covered
▪ Flexible sigmoidoscopy once every 5 years; OR ▪ Double contrast barium enema once every 5 years; OR ▪ Preventive colonoscopy age 50 and older, once every 10 years	No Cost to You	Not Covered
Family Planning ▪ Tubal ligation and associated services (reversal of sterilization is not a covered benefit) ▪ Insertion or implantation of birth control pellets, capsules or IUDs ▪ Fitting and insertion of diaphragms, rings or caps ▪ Injection of long acting contraceptives	No Cost to You	Not Covered
Smoking cessation ▪ Kick the Nic: smoking cessation; 12 week program *Note: Contact QCARE 1-888-795-6810*	No Cost to You	Not Covered
Professional Services		
Primary Care Physician (PCP) Office Visit ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures ▪ Routine Injectible Prescription Medications which include: 1st generation antibiotics, topical and local anesthesia, steroid, hormone and vitamin injections	**[$0-$500] Co-payment**	**[0%-100%] after Deductible**
Specialist Office Visit ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures	**[$0-$500] Co-payment**	**[0%-100%] after Deductible**
Professional services that are subject to Deductible and Coinsurance (in addition to the office Co-payment) ▪ Complex diagnostic services, such as advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests ▪ Other procedures, such as chemotherapy, radiation and infusion therapy ▪ Complex Injectible Prescription Medications which include: All specialty medications such as enbrel, humira, IV medications and high potency antibiotics (when obtained at a pharmacy, see *"Outpatient Prescription Drug Benefit Summary"* ▪ Complex procedures such as cystoscopy, colposcopy and invasive biopsies ▪ Services and procedures provided by a physician in a facility	**PCP: [$0-$500] Co-payment or Specialist: [$0-$500] Co-payment and [0%-100%] after Deductible**	**[0%-100%] after Deductible**
Inpatient Care - Room and Board		
▪ Inpatient care - room and board ▪ Skilled Nursing Facility and Inpatient Rehabilitation Services (combined 30 day limit per Calendar Year)	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Outpatient Care and Ambulatory Care Centers		
▪ Outpatient Care and Ambulatory Care Centers ▪ Observation Services ▪ Diagnostic Services - Advanced imaging, Lab & X-Ray ▪ Hospice services (limited to a lifetime maximum of 180 days) ▪ Home HealthCare (40 visits per Calendar Year)	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
▪ Outpatient Surgical Services	**[0%-100%] after Deductible**	
Emergency Services		
▪ Emergency Room, Urgent Care or ER Observation Services	**[0%-100%] after [Deductible]**	**[0%-100%] after [Deductible] or**
Transportation Services		
▪ Ambulance - Ground or Air ($1,000 maximum benefit per Calendar Year) *Note: Facility to facility ambulance transfer requires pre-authorization.*	**[0%-100%]**	**[0%-100%]**
Therapy Services		
▪ Physical Therapy ▪ Occupational Therapy ▪ Speech Therapy and Audiology Testing ▪ Chiropractic Care ▪ Cardiac Rehabilitation (36 visits per Calendar Year) *Note: Therapy services are limited to a combined maximum of 30 visits per Calendar Year. This does not include Cardiac Rehabilitation*	**[$0-$500] Co-payment**	**[0%-100%] after Deductible**
Maternity Services	**In-Network (You Pay)**	**Out-of-Network (You Pay)**
Physician Services		

▪ Routine Prenatal Lab	**[Paid in full] or [0%-100%] after Deductible**	**[0%-100%] after Deductible**
▪ Initial Office Visit	**[$0-$500] Co-payment**	
▪ All other services	**[0%-100%] after Deductible**	
Facility Services	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Infertility Diagnostic Services Only *Note: Treatment of infertility is not covered.*	**[0%-100%] after Deductible**	**Not Covered**
Mental Health and Substance Use Disorder Services		
▪ Inpatient Hospital Services - **[10 day limit per calendar year]**	**[0%-100%] after Deductible**	**[0%-100%] after Deductible or [Not Covered]**
▪ Professional Services (Office/**Outpatient** Visits) **[10 visit limit per calendar year]**	**[$0-$500] Co-payment**	
▪ Professional Services (Inpatient/**Outpatient** Facility)	**[0%-100%] after Deductible**	
Allergy Services		
▪ Office Visit and Allergy Testing	**PCP: [$0-$500] Co-payment or**	**[0%-100%] after Deductible**
▪ Allergy Shots	Paid in Full	**[0%-100%] after Deductible**
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME) ▪ $2,000 maximum benefit per Calendar Year	**[0%-100%] after Deductible**	**Not Covered**
Medical Supplies ▪ Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately.	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
▪ Provided in connection with home infusion therapy	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
▪ Provided in connection with Durable Medical Equipment	**[0%-100%] after Deductible**	Not Covered
Prosthetic and Orthotic Services and Devices ▪ Prosthetic Services and Prosthetic Devices ▪ Orthotic Services and Orthotic Devices *Note: QualChoice does not cover replacement or associated services more frequently than (1) time every three years unless Medically Necessary. See your Evidence of Coverage for more information.*	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Reconstructive Surgery ▪ Breast reconstruction following mastectomy ▪ Restoration due to acute trauma, infection or cancer *Note: These benefits are for physician/professional charges. For benefits related to these services for Inpatient or Outpatient charges, see Inpatient or Outpatient sections on page 2.*	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Transplantation Services ▪ Physician/Professional charges	**[0%-100%] after Deductible**	**Not Covered**
▪ Inpatient and Outpatient Charges *Note: Lifetime maximum of two transplants*	**[0%-100%] after Deductible**	
Diabetes Management Services ▪ Insulin Pumps ($5,500 benefit maximum per Calendar Year)	**[0%-100%] after Deductible**	**Not Covered**
▪ Supplies and equipment (Subject to $2,000 DME limit)	**[0%-100%] after Deductible**	
▪ Diabetic Education (1 training per lifetime)	**[$0-$500] Co-payment**	**[0%-100%] after Deductible**
Dental Care ▪ Accidental injury to sound and natural teeth $2,000 maximum benefit per accident	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Medical Foods for Phenylketonuria ▪ Benefits available after member has paid $2,400 per year	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Genetic Counseling and Testing *Note: Genetic testing is typically not covered, except in rare situations. When covered, these tests are subject to Deductible and Coinsurance. Talk with your physician. If genetic testing is done and there is no pre-authorization, you will be responsible for the charges. See medical policies at www.qualchoice.com for more information.*	No benefits if not pre-authorized **[0%-100%] after Deductible**	No benefits if not pre-authorized **[0%-100%] after Deductible**

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All benefit payments are based on the QualChoice Maximum Allowable Charge. Use of an Out-of-Network Provider may result in you being balance billed and higher out-of-pocket costs. Amounts in excess of the QualChoice Maximum Allowable Charge do not count toward annual Deductible or Coinsurance limits. See the "Member Financial Responsibility Comparison" section in the Evidence of Coverage.

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Annual Deductible ▪ Co-payments are not included in the annual Deductible ▪ In-Network and Out-of-Network Deductibles apply separately ▪ Family Deductible is not considered satisfied until at least **[2 to 5]** separate family members have satisfied their individual Deductibles ▪ Deductible amounts applied in the last quarter of a Calendar Year will carry over to the next Calendar Year ▪ The annual Deductible is calculated on a Calendar Year basis	**Individual: [$0-[$0-$2,000],000]** **Family: [$0-[$0-$2,000],000]**	**Individual: [$0-[$0-$2,000],000]** **Family: [$0-[$0-$2,000],000]**
Annual Out-of-Pocket Limit ▪ Applicable Coinsurance will apply until **[2 to 5]** separate family members meet their individual Out-of-Pocket Limits satisfying the family out-of-pocket limit ▪ Benefits will be paid at 100% of the Maximum Allowable Charge once the family annual Coinsurance limit is satisfied ▪ Out-of-Pocket limits apply separately to In-Network and Out-of-Network Benefits ▪ Co-payments do not apply toward your Out-of-Pocket Limit. You will continue to be responsible for Co-payments once the Out-of-Pocket Limit is reached ▪ Out-of-Pocket Limit & benefit limits are calculated on a Calendar Year basis	Individual: **[$0-$500,000]** Family: **[$0-$1,000,000]**	Individual: **[$0-$500,000]** Family: **[$0-$1,000,000]**
Coinsurance	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Preventive Care Services (Performed in the Office):		
QualChoice preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved QualChoice medical polices. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and QualChoice medical policies.		
Immunizations, including flu and pneumonia vaccines **Child Immunizations (age 0-18)** **Adult Immunizations (age 18+)** ▪ Diphtheria and Tetanus toxoid for ages over seven (Td), every 10 years ▪ Hepatitis B (Hep B) - once per lifetime ▪ Influenza, annually ▪ Pneumococcal Conjugate, adult over 55 or immunosuppressed ▪ Zoster, adult 60 and older ▪ HPV (covered age 9-18, females only) *Note: Immunizations for travel, school, work or recreation are not covered. See the "Physician Office Services" section in the Evidence of Coverage (EOC).*	Paid in Full	
Routine vision exam (limit 1 every 24 months)	**[$0-$500] Co-payment**	Not Covered
Well baby care, birth - to age 2	**[$0-$500] Co-payment**	**[0%-100%] after Deductible**
Well child care, ages 2-18	**[$0-$500] Co-payment**	**[0%-100%] after Deductible**
Other preventive services ▪ Annual physical ▪ Pap smear ▪ Screening mammogram (including breast exam) age 40 and over ▪ Prostate screenings for men age 40 and over	**PCP: [$0-$500] Co-payment or payment**	**[0%-100%] after Deductible**

Preventive Care Services, continued	In-Network (You Pay)	Out-of-Network (You Pay)
Other preventive services, continued ▪ Bone density screening tests, preventive for women age 65+ ▪ Fecal occult blood test annually	**PCP: [$0-$500] Co-payment or Specialist: [$0-$500] Co-payment**	**[0%-100%] after Deductible**
▪ Flexible sigmoidoscopy once every 5 years; OR ▪ Double contrast barium enema once every 5 years; OR ▪ Preventive colonoscopy age 50 and older, once every 10 years	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Family Planning ▪ Tubal ligation and associated services (reversal of sterilization is not a covered benefit) ▪ Insertion or implantation of birth control pellets, capsules or IUDs ▪ Fitting and insertion of diaphragms, rings or caps ▪ Injection of long acting contraceptives	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Smoking cessation ▪ Kick the Nic: smoking cessation; 12 week program *Note: Contact QCARE 1-888-795-6810*	No Cost to You	Not Covered
Professional Services		
Primary Care Physician (PCP) Office Visit ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures ▪ Routine Injectible Prescription Medications which include: 1st generation antibiotics, topical and local anesthesia, steroid, hormone and vitamin injections	**[$0-$500] Co-payment**	**[0%-100%] after Deductible**
Specialist Office Visit ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures	**[$0-$500] Co-payment**	**[0%-100%] after Deductible**
Professional services that are subject to Deductible and Coinsurance (in addition to the office Co-payment) ▪ Complex diagnostic services, such as advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests ▪ Other procedures, such as chemotherapy, radiation and infusion therapy ▪ Complex Injectible Prescription Medications which include: All specialty medications such as enbrel, humira, IV medications and high potency antibiotics (when obtained at a pharmacy, see *"Outpatient Prescription Drug Benefit Summary"* ▪ Complex procedures such as cystoscopy, colposcopy and invasive biopsies ▪ Services and procedures provided by a physician in a facility	**PCP: [$0-$500] Co-payment or Specialist: [$0-$500] Co-payment and [0%-100%] after Deductible**	**[0%-100%] after Deductible**
Inpatient Care - Room and Board		
▪ Inpatient care - room and board ▪ Skilled Nursing Facility and Inpatient Rehabilitation Services (combined 30 day limit per Calendar Year)	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Outpatient Care and Ambulatory Care Centers		
▪ Outpatient Care and Ambulatory Care Centers ▪ Observation Services ▪ Diagnostic Services - Advanced imaging, Lab & X-Ray ▪ Hospice services (limited to a lifetime maximum of 180 days) ▪ Home HealthCare (40 visits per Calendar Year)	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
▪ Outpatient Surgical Services	**[0%-100%] after Deductible**	
Emergency Services		
▪ Emergency Room, Urgent Care or ER Observation Services	**[0%-100%] after [Deductible] or [$0-$2,000] [Co-payment]**	**[0%-100%] after [Deductible] or [$0-$2,000] [Co-payment]**
Transportation Services		
▪ Ambulance - Ground or Air ($1,000 maximum benefit per Calendar Year) *Note: Facility to facility ambulance transfer requires pre-authorization.*	**[0%-100%]**	**[0%-100%]**
Therapy Services		
▪ Physical Therapy ▪ Occupational Therapy ▪ Speech Therapy and Audiology Testing ▪ Chiropractic Care ▪ Cardiac Rehabilitation (36 visits per Calendar Year) *Note: Therapy services are limited to a combined maximum of 30 visits per Calendar Year. This does not include Cardiac Rehabilitation*	**[$0-$500] Co-payment**	**[0%-100%] after Deductible**
Maternity Services	**In-Network (You Pay)**	**Out-of-Network (You Pay)**
Physician Services		

▪ Routine Prenatal Lab	**[Paid in full] or [0%-100%]**	**[0%-100%] after Deductible**
▪ Initial Office Visit	**[$0-$500] Co-payment**	
▪ All other services	**[0%-100%] after Deductible**	
Facility Services	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Infertility Diagnostic Services Only *Note: Treatment of infertility is not covered.*	**[0%-100%] after Deductible**	**Not Covered**
Mental Health and Substance Use Disorder Services		
▪ Inpatient Hospital Services - **[10 day limit per calendar year]**	**[0%-100%] after Deductible**	**[0%-100%] after Deductible or [Not Covered]**
▪ Professional Services (Office/**Outpatient** Visits) **[10 visit limit per calendar year]**	**[$0-$500] Co-payment**	
▪ Professional Services (Inpatient/**Outpatient** Facility)	**[0%-100%] after Deductible**	
Allergy Services		
▪ Office Visit and Allergy Testing	**PCP: [$0-$500] Co-payment or**	**[0%-100%] after Deductible**
▪ Allergy Shots	Paid in Full	**[0%-100%] after Deductible**
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME) ▪ $2,000 maximum benefit per Calendar Year	**[0%-100%] after Deductible**	**Not Covered**
Medical Supplies ▪ Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately.	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
▪ Provided in connection with home infusion therapy	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
▪ Provided in connection with Durable Medical Equipment	**[0%-100%] after Deductible**	Not Covered
Prosthetic and Orthotic Services and Devices ▪ Prosthetic Services and Prosthetic Devices ▪ Orthotic Services and Orthotic Devices *Note: QualChoice does not cover replacement or associated services more frequently than (1) time every three years unless Medically Necessary. See your Evidence of Coverage for more information.*	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Reconstructive Surgery ▪ Breast reconstruction following mastectomy ▪ Restoration due to acute trauma, infection or cancer *Note: These benefits are for physician/professional charges. For benefits related to these services for Inpatient or Outpatient charges, see Inpatient or Outpatient sections on page 2.*	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Transplantation Services ▪ Physician/Professional charges	**[0%-100%] after Deductible**	**Not Covered**
▪ Inpatient and Outpatient Charges *Note: Lifetime maximum of two transplants*	**[0%-100%] after Deductible**	
Diabetes Management Services ▪ Insulin Pumps ($5,500 benefit maximum per Calendar Year)	**[0%-100%] after Deductible**	
▪ Supplies and equipment (Subject to $2,000 DME limit)	**[0%-100%] after Deductible**	**Not Covered**
▪ Diabetic Education (1 training per lifetime)	**[$0-$500] Co-payment**	**[0%-100%] after Deductible**
Dental Care ▪ Accidental injury to sound and natural teeth $2,000 maximum benefit per accident	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Medical Foods for Phenylketonuria ▪ Benefits available after member has paid $2,400 per year	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Genetic Counseling and Testing *Note: Genetic testing is typically not covered, except in rare situations. When covered, these tests are subject to Deductible and Coinsurance. Talk with your physician. If genetic testing is done and there is no pre-authorization, you will be responsible for the charges. See medical policies at www.qualchoice.com for more information.*	No benefits if not pre-authorized **[0%-100%] after Deductible**	No benefits if not pre-authorized **[0%-100%] after Deductible**

QualChoice RightChoice Benefit Summary
Grandfathered Benefit Plan [xxxxx]
[Group Name]

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For both In-Network and Out-of-Network Benefits, some services may require pre-authorization by QualChoice. For details and to access the most current listing of services requiring pre-authorization, visit our website at www.qualchoice.com.

All benefit payments are based on the QualChoice Maximum Allowable Charge. Use of an Out-of-Network Provider may result in you being balance billed and higher out-of-pocket costs. Amounts in excess of the QualChoice Maximum Allowable Charge do not count toward annual Deductible or Coinsurance limits. See the "Member Financial Responsibility Comparison" section in the Evidence of Coverage.

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Annual Deductible ▪ Family Deductible is not considered satisfied until the entire family Deductible amount is reached ▪ The annual Deductible is calculated on a **[Calendar/Plan]** Year basis ▪ Deductible amounts applied in the last quarter of a **[Calendar/Plan]** Year will NOT carry over to the next **[Calendar/Plan]** Year	**Individual: [$0-$500,000]** **Family: [$0-$500,000]**	
Annual Out-of-Pocket Limit ▪ Applicable coinsurance will apply until the family out-of-pocket limit is satisfied ▪ Benefits will be paid at 100% of the Maximum Allowable Charge once the family annual coinsurance limit is satisfied ▪ Out-of-Pocket limits apply seperately to In-Network and Out-of-Network Benefits ▪ Out-of-Pocket Limit & benefit limits are calculated on a **[Calendar/Plan]** Year basis	**Individual: [$0-$500,000]** **Family: [$0-$1,000,000]**	**Individual: [$0-$500,000]** **Family: [$0-$1,000,000]**
Coinsurance	**[0%-100%]** after Deductible	**[0%-100%]** after Deductible
QualChoice preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved QualChoice medical polices. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and QualChoice medical policies.		
Immunizations, including flu and pneumonia vaccines **Child Immunizations (age 0-18)** **Adult Immunizations (age 18+)** ▪ Diphtheria and Tetanus toxoid for ages over seven (Td), every 10 years ▪ Hepatitis B (Hep B) - once per lifetime ▪ Influenza, annually ▪ Pneumococcal Conjugate, adult over 55 or immunosuppressed ▪ Zoster, adult 60 and older ▪ HPV (covered age 9-18, females only) *Note: Immunizations for travel, school, work or recreation are not covered. See the "Physician Office Services" section in the Evidence of Coverage (EOC).*	Paid in Full	
Well baby care, birth - to age 2 Well child care, ages 2-18 Other preventive services ▪ Annual physical ▪ Pap smear ▪ Screening mammogram (including breast exam) age 40 and over ▪ Prostate screenings for men age 40 and over	[0%-100%] after Deductible, applies after **[$0-$5,000]** annual Preventive Services Maximum has been met.	**[0%-100%] after Deductible**
Routine vision exam (limit 1 every 24 months)	applies after [$0-$5,000] annual Preventive Services	Not Covered

Preventive Care Services, continued	In-Network (You Pay)	Out-of-Network (You Pay)
Other preventive services, continued ▪ Bone density screening tests, preventive for women age 65+ ▪ Fecal occult blood test annually ▪ Flexible sigmoidoscopy once every 5 years, OR ▪ Double contrast barium enema once every 5 years; OR ▪ Preventive colonoscopy age 50 and older, once every 10 years	[0%-100%] after Deductible, applies after **[$0-$5,000]** annual Preventive Services Maximum has been met.	**[0%-100%] after Deductible**
Family Planning ▪ Tubal ligation and associated services (reversal of sterilization is not a ▪ Insertion or implantation of birth control pellets, capsules or IUDs ▪ Fitting and insertion of diaphragms, rings or caps ▪ Injection of long acting contraceptives	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Smoking cessation ▪ Kick the Nic: smoking cessation; 12 week program *Note: Contact QCARE 1-888-795-6810*	Paid in Full	Not Covered
Professional Services		
Primary Care Physician (PCP) Office Visit ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures ▪ Routine Injectible Prescription Medications which include: 1st generation antibiotics, topical and local anesthesia, steroid, hormone and vitamin injections	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Specialist Office Visit ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Professional services that are subject to Deductible and Coinsurance ▪ Complex diagnostic services, such as advanced imaging (CT, MRI, MRA, MRA, Nuclear Medicine), DEXA, Treadmill tests ▪ Other procedures, such as chemotherapy, radiation therapy and infusion therapy ▪ Complex Injectible Prescription Medications which include: All specialty medications such as, enbrel, humira, IV medications and high potency antibiotics (when obtained at a pharmacy, see *"Outpatient Prescription Drug Benefit Summary"* ▪ Complex procedures such as cystoscopy, colposcopy and invasive biopsies ▪ Services and procedures provided by a physician in a facility	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Inpatient Care - Room and Board		
▪ Inpatient care - room and board ▪ Skilled Nursing Facility and Inpatient Rehabilitation Services (combined 30 day limit per **[Calendar/Plan]** Year)	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Outpatient Care and Ambulatory Care Centers		
▪ Outpatient Care and Ambulatory Care Centers ▪ Observation Services ▪ Diagnostic Services - Advanced imaging, Lab & X-Ray ▪ Hospice services (limited to a lifetime maximum of 180 days) ▪ Home Health Care (40 visits per **[Calendar/Plan]** Year) ▪ Outpatient Surgical Services	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Emergency Services		
▪ Emergency Room, Urgent Care or ER Observation Services	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Transportation Services		
▪ Ambulance - Ground or Air ($1,000 maximum benefit per ([**Calendar/Plan**] Year) *Note: Facility to facility ambulance transfer requires pre-authorization.*	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**

Therapy Services		
▪ Physical Therapy ▪ Occupational Therapy ▪ Speech Therapy and Audiology Testing ▪ Chiropractic Care ▪ Audiology Care ▪ Cardiac Rehabilitation (36 visits per **[Calendar/Plan]** Year) *Note: Therapy services are limited to a combined maximum of 30 visits per **[Calendar/Plan]** Year. This does not include Cardiac Rehabilitation.*	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Maternity Services	**In-Network (You Pay)**	**Out-of-Network (You Pay)**
Physician Services ▪ Routine Prenatal Lab ▪ Initial Office Visit ▪ All other services	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Facility Services	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Infertility Diagnostic Services Only *Note: Treatment of infertility is not covered.*	**[0%-100%] after Deductible**	**[0%-100% after Deductible] or [Not Covered]**
Mental Health and Substance Use Disorder Services		
▪ Inpatient Hospital Services - [**10 day limit per [Calendar/Plan] year**]	**[0%-100%] after Deductible**	**[0%-100% after Deductible] or [Not Covered]**
▪ Professional Services (Office/**Outpatient** Visits) - [**10 visit limit per [Calendar/Plan] year**]	**[0%-100%] after Deductible**	
▪ Professional Services (Inpatient/Outpatient Facility)	**[0%-100%] after Deductible**	
Allergy Services		
▪ Office Visit ▪ Allergy testing and shots	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME) ▪ $2,000 maximum benefit per **[Calendar/Plan]** Year	**[0%-100%] after Deductible**	**[0%-100% after Deductible] or [Not Covered]**
Medical Supplies ▪ Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately ▪ Provided in connection with home infusion therapy	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
▪ Provided in connection with Durable Medical Equipment	**[0%-100%] after Deductible**	**[0%-100% after Deductible] or [Not Covered]**
Prosthetic and Orthotic Services and Devices ▪ Prosthetic Services and Prosthetic Devices ▪ Orthotic Services and Orthotic Devices *Note: QualChoice does not cover replacement or associated services more frequently than (1) time every three years unless Medically Necessary. See your Evidence of Coverage for more information.*	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Reconstructive Surgery ▪ Breast reconstruction following mastectomy ▪ Restoration due to acute trauma, infection or cancer	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Transplantation Services ▪ *Lifetime maximum of two transplants*	**[0%-100%] after Deductible**	**[0%-100% after Deductible] or [Not Covered]**
Diabetes Management Services ▪ Supplies and equipment (Subject to $2,000 DME limit) ▪ Insulin Pumps ($5,500 benefit maximum per **[Calendar/Plan]** Year)	**[0%-100%] after Deductible**	**[0%-100% after Deductible] or [Not Covered]**
▪ Diabetic Education (1 training per lifetime)	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Dental Care ▪ **[Preventive exam (limit 1 every 12 months)]** ▪ Accidental injury to sound and natural teeth $2,000 maximum benefit per accident	**[Paid in Full]** **[0%-100%] after Deductible**	**[No cost to you]** **[0%-100%] after Deductible**
Medical Foods for Phenylketonuria ▪ Benefits available after member has paid $2,400 per year	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Genetic Counseling and Testing *Note: Genetic testing is typically not covered, except in rare situations. When covered, these tests are subject to Deductible and Coinsurance. Talk with your physician. If genetic testing is done and there is no pre-authorization, you will be responsible for the charges. See medical policies at www.qualchoice.com for more information.*	No benefits if not pre-authorized **[0%-100%] after Deductible**	No benefits if not pre-authorized **[0%-100%] after Deductible**

QualChoice RightChoice Benefit Summary
Non-Grandfathered Benefit Plan [xxxxx]
[Group Name]

This benefit summary is part of the Evidence of Coverage (EOC), Form QCA POS HDHP (10/1/10) as amended by FIRST AMENDMENT with Autism to QCA POS HDHP (10-1-10) EOC (8-1-2011) and subject to all benefit terms and conditions, limitations and exclusions included in the Evidence of Coverage. This benefit summary is intended only to highlight your benefits and should not be relied upon soley to determine coverage. Please refer to the Evidence of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. In the event the language in the Evidence of Coverage is different than this benefit summary, the Evidence of Coverage prevails.

For both In-Network and Out-of-Network Benefits, some services may require pre-authorization by QualChoice. For details and to access the most current listing of services requiring pre-authorization, visit our website at www.qualchoice.com.

All benefit payments are based on the QualChoice Maximum Allowable Charge. Use of an Out-of-Network Provider may result in you being balance billed and higher out-of-pocket costs. Amounts in excess of the QualChoice Maximum Allowable Charge do not count toward annual Deductible or Coinsurance limits. See the "Member Financial Responsibility Comparison" section in the Evidence of Coverage.

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Annual Deductible ▪ Family Deductible is not considered satisfied until the entire family Deductible amount is reached ▪ The annual Deductible is calculated on a **[Calendar/Plan]** Year basis ▪ Deductible amounts applied in the last quarter of a **[Calendar/Plan]** Year will NOT carry over to the next **[Calendar/Plan]** Year	**Individual: [$0-$500,000]** **Family: [$0-$500,000]**	
Annual Out-of-Pocket Limit ▪ Applicable coinsurance will apply until the family out-of-pocket limit is satisfied ▪ Benefits will be paid at 100% of the Maximum Allowable Charge once the family annual coinsurance limit is satisfied ▪ Out-of-Pocket limits apply seperately to In-Network and Out-of-Network Benefits ▪ Out-of-Pocket Limit & benefit limits are calculated on a **[Calendar/Plan]** Year basis	**Individual: [$0-$500,000]** **Family: [$0-$1,000,000]**	**Individual: [$0-$500,000]** **Family: [$0-$1,000,000]**
Coinsurance	**[0%-100%]** after Deductible	**[0%-100%]** after Deductible
QualChoice preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved QualChoice medical polices. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and QualChoice medical policies.		
Immunizations, including flu and pneumonia vaccines **Child Immunizations (age 0-18)** **Adult Immunizations (age 18+)** ▪ Diphtheria and Tetanus toxoid for ages over seven (Td), every 10 years ▪ Hepatitis B (Hep B) - once per lifetime ▪ Influenza, annually ▪ Pneumococcal Conjugate, adult over 55 or immunosuppressed ▪ Zoster, adult 60 and older ▪ HPV (covered age 9-18, females only) *Note: Immunizations for travel, school, work or recreation are not covered. See the "Physician Office Services" section in the Evidence of Coverage (EOC).*	Paid in Full	
Well baby care, birth - to age 2 Well child care, ages 2-18 Other preventive services ▪ Annual physical ▪ Pap smear ▪ Screening mammogram (including breast exam) age 40 and over ▪ Prostate screenings for men age 40 and over	No Cost to You	**Not Covered**
Routine vision exam (limit 1 every 24 months)	[0%-100%] after Deductible	Not Covered

Preventive Care Services, continued	In-Network (You Pay)	Out-of-Network (You Pay)
Other preventive services, continued ▪ Bone density screening tests, preventive for women age 65+ ▪ Fecal occult blood test annually ▪ Flexible sigmoidoscopy once every 5 years, OR ▪ Double contrast barium enema once every 5 years; OR ▪ Preventive colonoscopy age 50 and older, once every 10 years	No Cost to You	**Not Covered**
Family Planning ▪ Tubal ligation and associated services (reversal of sterilization is not a ▪ Insertion or implantation of birth control pellets, capsules or IUDs ▪ Fitting and insertion of diaphragms, rings or caps ▪ Injection of long acting contraceptives	No Cost to You	Not Covered
Smoking cessation ▪ Kick the Nic: smoking cessation; 12 week program *Note: Contact QCARE 1-888-795-6810*	Paid in Full	Not Covered
Professional Services		
Primary Care Physician (PCP) Office Visit ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures ▪ Routine Injectible Prescription Medications which include: 1st generation antibiotics, topical and local anesthesia, steroid, hormone and vitamin injections	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Specialist Office Visit ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Professional services that are subject to Deductible and Coinsurance ▪ Complex diagnostic services, such as advanced imaging (CT, MRI, MRA, MRA, Nuclear Medicine), DEXA, Treadmill tests ▪ Other procedures, such as chemotherapy, radiation therapy and infusion therapy ▪ Complex Injectible Prescription Medications which include: All specialty medications such as, enbrel, humira, IV medications and high potency antibiotics (when obtained at a pharmacy, see *"Outpatient Prescription Drug Benefit Summary"* ▪ Complex procedures such as cystoscopy, colposcopy and invasive biopsies ▪ Services and procedures provided by a physician in a facility	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Inpatient Care - Room and Board		
▪ Inpatient care - room and board ▪ Skilled Nursing Facility and Inpatient Rehabilitation Services (combined 30 day limit per **[Calendar/Plan]** Year)	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Outpatient Care and Ambulatory Care Centers		
▪ Outpatient Care and Ambulatory Care Centers ▪ Observation Services ▪ Diagnostic Services - Advanced imaging, Lab & X-Ray ▪ Hospice services (limited to a lifetime maximum of 180 days) ▪ Home Health Care (40 visits per **[Calendar/Plan]** Year) ▪ Outpatient Surgical Services	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Emergency Services		
▪ Emergency Room, Urgent Care or ER Observation Services	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Transportation Services		
▪ Ambulance - Ground or Air ($1,000 maximum benefit per ([**Calendar/Plan**] Year) *Note: Facility to facility ambulance transfer requires pre-authorization.*	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**

Therapy Services		
▪ Physical Therapy ▪ Occupational Therapy ▪ Speech Therapy and Audiology Testing ▪ Chiropractic Care ▪ Audiology Care ▪ Cardiac Rehabilitation (36 visits per **[Calendar/Plan]** Year) *Note: Therapy services are limited to a combined maximum of 30 visits per **[Calendar/Plan]** Year. This does not include Cardiac Rehabilitation.*	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Maternity Services	**In-Network (You Pay)**	**Out-of-Network (You Pay)**
Physician Services ▪ Routine Prenatal Lab ▪ Initial Office Visit ▪ All other services	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Facility Services	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Infertility Diagnostic Services Only *Note: Treatment of infertility is not covered.*	**[0%-100%] after Deductible**	**[0%-100% after Deductible] or [Not Covered]**
Mental Health and Substance Use Disorder Services		
▪ Inpatient Hospital Services - [**10 day limit per [Calendar/Plan] year**]	**[0%-100%] after Deductible**	**[0%-100% after Deductible] or [Not Covered]**
▪ Professional Services (Office/**Outpatient** Visits) - [**10 visit limit per [Calendar/Plan] year**]	**[0%-100%] after Deductible**	
▪ Professional Services (Inpatient/Outpatient Facility)	**[0%-100%] after Deductible**	
Allergy Services		
▪ Office Visit ▪ Allergy testing and shots	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME) ▪ $2,000 maximum benefit per **[Calendar/Plan]** Year	**[0%-100%] after Deductible**	**[0%-100% after Deductible] or [Not Covered]**
Medical Supplies ▪ Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately ▪ Provided in connection with home infusion therapy	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
▪ Provided in connection with Durable Medical Equipment	**[0%-100%] after Deductible**	**[0%-100% after Deductible] or [Not Covered]**
Prosthetic and Orthotic Services and Devices ▪ Prosthetic Services and Prosthetic Devices ▪ Orthotic Services and Orthotic Devices *Note: QualChoice does not cover replacement or associated services more frequently than (1) time every three years unless Medically Necessary. See your Evidence of Coverage for more information.*	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Reconstructive Surgery ▪ Breast reconstruction following mastectomy ▪ Restoration due to acute trauma, infection or cancer	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Transplantation Services ▪ *Lifetime maximum of two transplants*	**[0%-100%] after Deductible**	**[0%-100% after Deductible] or [Not Covered]**
Diabetes Management Services ▪ Supplies and equipment (Subject to $2,000 DME limit) ▪ Insulin Pumps ($5,500 benefit maximum per **[Calendar/Plan]** Year)	**[0%-100%] after Deductible**	**[0%-100% after Deductible] or [Not Covered]**
▪ Diabetic Education (1 training per lifetime)	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Dental Care ▪ **[Preventive exam (limit 1 every 12 months)]** ▪ Accidental injury to sound and natural teeth $2,000 maximum benefit per accident	**[Paid in Full]** **[0%-100%] after Deductible**	**[No cost to you]** **[0%-100%] after Deductible**
Medical Foods for Phenylketonuria ▪ Benefits available after member has paid $2,400 per year	**[0%-100%] after Deductible**	**[0%-100%] after Deductible**
Genetic Counseling and Testing *Note: Genetic testing is typically not covered, except in rare situations. When covered, these tests are subject to Deductible and Coinsurance. Talk with your physician. If genetic testing is done and there is no pre-authorization, you will be responsible for the charges. See medical policies at www.qualchoice.com for more information.*	No benefits if not pre-authorized **[0%-100%] after Deductible**	No benefits if not pre-authorized **[0%-100%] after Deductible**

This benefit summary is part of the Evidence of Coverage, Form QC POS(10-01-10) as amended by FIRST AMENDMENT with Autism to QCA POS (10-1-10) and Outpatient Prescription Drug Rider and is subject to all benefit terms and conditions, limitations and exclusions contained therein.
This benefit summary is intended only to highlight your benefits for Outpatient Prescription Drugs and should not be relied upon soley to determine coverage. Please refer to your Outpatient Prescription Drug Rider and Evidence of Coverage for a complete lising of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this benefit summary conflicts in any way with the Outpatient Prescription Drug Rider, the Outpatient Prescription Drug Rider and Evidence of Coverage will prevail.

For information about specific medications, visit our website at www.qualchoice.com.
Some medications may require pre-authorization by QualChoice. For details and to access the most current listing of services requiring pre-authorization, visit www.qualchoice.com.

Tier Definitions:

Tier 1 medications are the lowest cost share option, as shown below. For the lowest out-of-pocket expense, you should always consider Tier 1 if you and your doctor decide they are appropriate for your treatment.

Tier 2 medications require a tier 2 cost share, as shown below. Consider Tier 2 medications if you and you doctor decide that a Tier 2 medication is the most approporiate to treat your condition.

Tier 3 medications require a Tier 3 cost share, as shown below. If your medication is in Tier 3, ask your doctor whether there are Tier 1 or Tier 2 alternatives that may be appropriate for your treatment.

[NOTE: If a covered brand-name product is chosen by the member when a generic equivalent is available, you will pay the Tier 3 co-payment plus the difference in cost of the brand name product and the generic product.]

Tier 4 medications are not included on the formulary. Almost all new prescription medications that are not listed in the formulary are included in Tier 4. Member pays 100% of the QualChoice discounted rate.

Tier 5 medications are generally classified as specialty medications and are generally only available through a specialty pharmacy, when not dispensed or administered by your physician in his/her office.

(See QC website for list of specialty meds covered under pharmacy benefit.) All else, see medical benefit.

Many Tier 5 medications require prior-authorization and are at the highest level of cost share.

Payment Procedures

Network Pharmacy

- You must pay the applicable cost sharing amount to the network pharmacy at the time the prescription is filled. The pharmacy will then submit the claim for reimbursement.

Out-of-Network Pharmacy

- You must pay the full amount of the prescription to the out-of-network pharmacy.
- You can then request reimbursement from QualChoice by submitting your receipt from the pharmacy, along with a QualChoice claim form.
- Reimbursement to you will be based on the contract rate for the drug dispensed, less a $2.00 processing fee.

Prescription Benefits In-Network	Retail (You Pay)	Mail Order (You Pay)
Co-payment Amounts		
▪ Tier 1	[$0-$500] [Co-payment]	[$0-$500] [Co-payment]
▪ Tier 2	[$0-$500] [Co-payment]	[$0-$500] [Co-payment]
▪ Tier 3[* (see Tier 3 Note above)]	[$0-$500] [Co-payment]	[$0-$500] [Co-payment]
▪ Tier 4	100%	100%
▪ Tier 5	[See Medical Benefits] and/or [$0-$500] [Co-payment]	[See Medical Benefits] and/or [$0-$500] [Co-payment]
NOTE: If dispensed in your physician office or at a facility - see medical benefits		
Coinsurance Amounts		
▪ Tier 1	[0%-100%] [after Deductible]	[0%-100%] [after Deductible]
▪ Tier 2	[0%-100%] [after Deductible]	[0%-100%] [after Deductible]
▪ Tier 3	[0%-100%] [after Deductible]	[0%-100%] [after Deductible]
▪ Tier 4	100%	100%
▪ Tier 5	[See Medical Benefits] and/or [0% to 100%] [after Deductible]	[See Medical Benefits] and/or [0% to 100%] [after Deductible]
Deductible	[$0-$200,000]	[$0-$200,000]

Contraceptive Coverage

- All oral contraceptives in either formulary Tiers 1 or 2 (all formulary options) - No Cost to You. (No coverage Out-of-Network)
  - Oral contraceptives in Tier 3 - Normal cost sharing, see Tier 3 above
- Ortho Evra patch, Nuvaring, Caps and Diaphragms - No Cost to You (No coverage Out-of-Network)
- Emergency contraceptives, e.g. Plan B, Ella - no cost sharing with a prescription, otherwise, not a covered benefit
- Over-the-counter birth control methods, e.g. gels, creams, condoms, etc. - not a covered benefit
- Abortion or abortifacient drugs - not a covered benefit

Limitations

- Retail pharmacy - One monthly cost sharing amount per 30-day supply
- Mail order pharmacy - 3 monthly cost sharing amounts per 90-day supply

Note: All new prescriptions are limited to a 30-day supply. Refills are limited to a 90-day supply at certain contracted pharmacies and through mail order.
Insulin and syringes will be covered with one monthly cost sharing amount for each 30-day supply, if filled at the same time.
Test strips and lancets will be covered with one monthly cost sharing amount for each 30-day supply, if filled at the same time.
Contact a Health Coach if you need assistance obtaining a new glucometer. 1-888-795-6810

Step Therapy

Certain medications may be required to be used before another medication is covered. Step therapy is the process of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy and progressing to other and more costly therapy if the first line medication fails. **Examples** of step therapy drugs under this plan include anti-hypertensive and Attention Deficit Disorder (ADD) medications.
Contact Customer Service at 1-800-235-7111 for more details.

Benefit Details

- Benefit Details are subject to all benefit terms, condidtions, limitations and exclusions
- Benefits are provided for formulary prescription drugs when prescribed by a physician or by a licensed health care provider within the scope of their license.
- Benefits are available through a network pharmacy, a network mail order pharmacy or an out-of-network pharmacy, provided that the drug is a Covered Prescription Drug.
- Benefits include compound prescriptions when the compound contains at least one prescription drug.
- Coverage is provided for contraceptives ("Birth Control") including oral, injectable and hormonal contraceptives.

Exclusions

Examples of drugs that we will not pay for are listed below. A complete listing is in the Outpatient Prescription Drug Rider.

- Experimental or investigational drugs or research drugs;
- Over-the-counter medications;
- Cosmetic agents, including, but not limited to, Retin-A for enrollees over age 25;
- Erectile dysfunction drugs, including but not limited to, impotency;
- Drugs for which there is a therapeutically equivalent over-the-counter drug;
- Oral or topical medication for hair loss;
- Smoking cessation medications, except for persons enrolled in the QualChoice "Kick the Nic" program;
- Smoking cessation devices;
- Drugs prescribed to treat infertility;
- Weight loss medication; appetite suppressants; anti-obesity drugs; anorexiants;
- General vitamins;
- Drugs whose primary purpose is the removal, destruction, or interference with the implantation of a fertilized ovum, embryo, or fetus;
- A drug prescribed as part of treatment to change an Enrollee's sex from one gender to another; and Over-the-counter birth control items

This benefit summary is part of the Evidence of Coverage, Form QC POS HDHP(10-01-10) as amended by FIRST AMENDMENT with Autism to QCA POS/HDHP (10-1-10) and Outpatient PrescriptionDrug Rider and is subject to all benefit terms and conditions, limitations and exclusions contained therein.
This benefit summary is intended only to highlight your benefits for Outpatient Prescription Drugs and should not be relied upon soley to determine coverage. Please refer to your Outpatient Prescription Drug Rider and Evidence of Coverage for a complete lising of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this benefit summary conflicts in any way with the Outpatient Prescription Drug Rider, the Outpatient Prescription Drug Rider and Evidence of Coverage will prevail.

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Some medications may require pre-authorization by QualChoice. For details and to access the most current listing of services requiring pre-authorization, visit www.qualchoice.com.

Tier Definitions:
Tier 1 medications are the lowest cost share option, as shown below. For the lowest out-of-pocket expense, you should always consider Tier 1 if you and your doctor decide they are appropriate for your treatment.
Tier 2 medications require a tier 2 cost share, as shown below. Consider Tier 2 medications if you and you doctor decide that a Tier 2 medication is the most approporiate to treat your condition.
Tier 3 medications require a Tier 3 cost share, as shown below. If your medication is in Tier 3, ask your doctor whether there are Tier 1 or Tier 2 alternatives that may be appropriate for your treatment.
[NOTE: If a covered brand name product is chosen by the member when a generic equivalent is available, the cost difference between the brand product and the generic product will be the responsibility of the member and will not apply to the annual deductible or out-of-pocket maximum amounts.]
Tier 4 medications are not included on the formulary. Almost all new prescription medications that are not listed in the formulary are included in Tier 4. Member pays 100% of the QualChoice discounted rate.
Tier 5 medications are generally classified as specialty medications and are generally only available through a specialty pharmacy, when not dispensed or administered by your physician in his/her office.
(See QC website for list of specialty meds covered under pharmacy benefit.) All else, see medical benefit.
Many Tier 5 medications require prior-authorization and are at the highest level of cost share.

Payment Procedures

Network Pharmacy

- You must pay the applicable cost sharing amount to the network pharmacy at the time the prescription is filled. The pharmacy will then submit the claim for reimbursement.

Out-of-Network Pharmacy

- You must pay the full amount of the prescription to the out-of-network pharmacy.
- You can then request reimbursement from QualChoice by submitting your receipt from the pharmacy, along with a QualChoice claim form.
- Reimbursement to you will be based on the contract rate for the drug dispensed, less a $2.00 processing fee.

Prescription Benefits In-Network	Retail (You Pay)	Mail Order (You Pay)
Co-payment Amounts		
▪ Tier 1	Not Applicable	Not Applicable
▪ Tier 2	Not Applicable	Not Applicable
▪ Tier 3	Not Applicable	Not Applicable
▪ Tier 4	100%	100%
▪ Tier 5	[See Medical Benefits] and/or [0% to 100%] [after Deductible]	[See Medical Benefits] and/or [0% to 100%] [after Deductible]
NOTE: If dispensed in your physician office or at a facility - see medical benefits		
Coinsurance Amounts		
▪ Tier 1	[0%-100%]after Deductible	[0%-100%] after Deductible
▪ Tier 2	[0%-100%]after Deductible	[0%-100%] after Deductible
▪ Tier 3* (see Tier 3 Note above)	[0%-100%]after Deductible	[0%-100%] after Deductible
▪ Tier 4	100%	100%
▪ Tier 5	[See Medical Benefits] and/or	[See Medical Benefits] and/or [0% to
Deductible	[$0-$10,000] (Individual)/ [$0-$20,000] (Family)	

Contraceptive Coverage

- All oral contraceptives in either formulary Tiers 1 or 2 (all formulary options) - No Cost to You. (No coverage Out-of-Network)
  - Oral contraceptives in Tier 3 - Normal cost sharing, see Tier 3 above
- Ortho Evra patch, Nuvaring, Caps and Diaphragms - No Cost to You (No coverage Out-of-Network)
- Emergency contraceptives, e.g. Plan B, Ella - no cost sharing with a prescription, otherwise, not a covered benefit
- Over-the-counter birth control methods, e.g. gels, creams, condoms, etc. - not a covered benefit
- Abortion or abortifacient drugs - not a covered benefit

Limitations

- Retail pharmacy - One monthly cost sharing amount per [30-31]-day supply
- Mail order pharmacy - [1-5] monthly cost sharing amounts per 90-day supply

Note: All new prescriptions are limited to a [30-31]-day supply. Refills are limited to a 90-day supply at certain contracted pharmacies and through mail order.
Insulin and syringes will be covered with one monthly cost sharing amount for each [30-31]-day supply, if filled at the same time.
Test strips and lancets will be covered with one monthly cost sharing amount for each [30-31]-day supply, if filled at the same time.
Contact a Health Coach if you need assistance obtaining a new glucometer. 1-888-795-6810

Step Therapy

Certain medications may be required to be used before another medication is covered. Step therapy is the process of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy and progressing to other and more costly therapy if the first line medication fails. **Examples** of step therapy drugs under this plan include anti-hypertensive and Attention Deficit Disorder (ADD) medications.
Contact Customer Service at 1-800-235-7111 for more details.

Benefit Details

- Benefit Details are subject to all benefit terms, condidtions, limitations and exclusions
- Benefits are provided for formulary prescription drugs when prescribed by a physician or by a licensed health care provider within the scope of their license.
- Benefits are available through a network pharmacy, a network mail order pharmacy or an out-of-network pharmacy, provided that the drug is a Covered Prescription Drug.
- Benefits include compound prescriptions when the compound contains at least one prescription drug.
- Coverage is provided for contraceptives ("Birth Control") including oral, injectable and hormonal contraceptives.

Exclusions

Examples of drugs that we will not pay for are listed below. A complete listing is in the Outpatient Prescription Drug Rider.

- Experimental or investigational drugs or research drugs;
- Over-the-counter medications;
- Cosmetic agents, including, but not limited to, Retin-A for enrollees over age 25;
- Erectile dysfunction drugs, including but not limited to, impotency;
- Drugs for which there is a therapeutically equivalent over-the-counter drug;
- Oral or topical medication for hair loss;
- Smoking cessation medications, except for persons enrolled in the QualChoice "Kick the Nic" program;
- Smoking cessation devices;
- Drugs prescribed to treat infertility;
- Weight loss medication; appetite suppressants; anti-obesity drugs; anorexiants;
- General vitamins;
- Drugs whose primary purpose is the removal, destruction, or interference with the implantation of a fertilized ovum, embryo, or fetus;
- A drug prescribed as part of treatment to change an Enrollee's sex from one gender to another; and Over-the-counter birth control items

State:	*Arkansas*	**Filing Company:**	*QCA Health Plan, Inc.*
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.001B Any Size Group - POS*		
Product Name:	*QualChoice Group POS*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification	Approved-Closed	10/17/2012
Comments:			
Attachment(s):			
PPO Benefit Summary Changes Flesch Letter Oct 2012.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Application	Approved-Closed	10/17/2012
Comments:	The form number of the application is 0810+MK+014_GRPAPPCVRG.		

		Item Status:	**Status Date:**
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	10/17/2012
Bypass Reason:	Not applicable to this filing.		
Comments:			

QualChoice

October 15, 2012

Ms. Rosalind Minor
Arkansas Department of Insurance
Life and Health Division
1200 West Third Street
Little Rock, AR 72201-1904

RE: QCA Health Plan POS Medical and Prescription Drug Benefit Summary Filing To Reflect Changes In Contraceptive Coverage

Dear Ms. Minor:

This certifies that the documents being filed in conjunction with this letter do not met the minimum score of forty (40) on the Flesch reading ease test as specified in Ark. Stat. Ann. § 23-80-206.

Although the score is lower than the minimum required, it should be approved in accordance with Ark. Stat. Ann. 23-80-207 and warranted due to the nature of the policy form and necessary inclusion of medical terminology and language drafted to conform to state and federal law.

Please feel free to contact me at any time should you need additional information or have any questions or comments.

Sincerely,

James W. Couch
Vice President of Compliance
jim.couch@qualchoice.com
(501) 219-5118